STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155273	A. BUILDING _____ B. WING _____	R 10/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CYPRESS GROVE REHABILITATION CENTER	**4255 MEDWELL DR NEWBURGH, IN 47630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS	{F 000}		

This visit is for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 8/27/14.

This visit was in conjunction with the Investigation of the Complaint IN 000155858.

Survey Dates: October 5, 7, 8, and 9, 2014

Facility Number: 000173
Provider Number: 155273
AIM Number: 100290920

Survey Team:
Barbara Fowler RN TC (10/7, 10/9/2014)
Denise Schwandner RN (10/7, 10/8, 10/9/2014)
Diana Perry RN (10/7, 10/8, 10/9/2014)
Anna Villain RN

Census Bed Type:
SNF/NF: 70
Total: 70

Census Payor Type:
Medicare: 5
Medicaid: 46
Other: 19
Total: 70

Sample: 18

Cypress Grove Rehabilitation Center was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Recertification and State Licensure Survey.

Quality review completed on October 11, 2014, by

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155273	A. BUILDING _____ B. WING _____	R 10/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 000}	Continued From page 1 Janelyn Kulik RN.	{F 000}		